AT THE FOREFRONT
UChicago Medicine

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION TO UNIVERSITY OF CHICAGO

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birthdate:		**Medical Record Number:**	
Address:			
City:	**State:**	**Zip:**	**Phone:**

The University of Chicago Organized Health Care Arrangement ("UC OHCA") consists of the University of Chicago Medical Center, portions of the University of Chicago that support the activities of health care, UCM Community Physicians, UCM Care Network Medical Group and Primary Healthcare Associates, SC.

Section II: RECIPIENT and PURPOSE

When I sign this Authorization, I will allow the University of Chicago Medicine to disclose the health information listed below to University personnel employed in the following offices the (*check all that* apply) (collectively, the "University"):

- ❑ University of Chicago's Dean and on Call Dean's Office
- ❑ University of Chicago Housing Department
- ❑ UChicago Student Wellness
- ❑ Other

_____

For the purpose of (*check all that apply*):

- ❑ Assisting me with my care at University of Chicago Medicine
- ❑ Assisting me with my transition back to campus and classes, to access relevant community services, and, if I am a resident of University of Chicago housing, for housing
- ❑ Care coordination with UChicago Student Wellness
- ❑ Other

_____

THE INFORMATION TO BE DISCLOSED: The following information may be disclosed under this Authorization:

- ❑ The fact that I am in the hospital
- ❑ My expected discharge date
- ❑ My discharge plan
- ❑ Allow the Dean on Call to visit me
- ❑ My medical condition
- ❑ Other

_____

In addition, I specifically allow the following information to be disclosed under this Authorization:

- ❑ Information about a Mental Illness or Developmental Disability
- ❑ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ❑ Information about Communicable Diseases
- ❑ Information about Sexually Transmitted Disease(s)
- ❑ Information about Substance (i.e., alcohol or drug) Abuse
- ❑ Information about Abuse of an Adult with a Disability
- ❑ Information about Sexual Assault
- ❑ Information about Child Abuse and Neglect
- ❑ Information about Genetic Testing
- ❑ Information about Infertility/IVF/Artificial Insemination
- ❑ Information about Domestic Violence

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Section III: EFFECTIVE DATE

This authorization begins on _____ and it will remain in effect until the purpose is fulfilled.

I understand that once my health information is disclosed to the University, the UC OHCA cannot guarantee it will not be re-disclosed to a third party or as required or permitted by law and that, once disclosed, such information may not be subject to the Health Insurance Portability and Accountability Act (HIPAA). I understand that I can discuss this with the University, the Dean, or UChicago Student Wellness.

I understand that any health information disclosed by the UC OHCA to the University may not be covered by the UC OHCA's policies relating to patient data or HIPAA and will instead be subject to the University's policies applicable to such data.

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except that, if my treatment is for the sole purpose of creating health information for disclosure to the University, then the UC OHCA may refuse to treat me if I do not sign this Authorization. This Authorization will remain in effect until revoked or, if earlier, until the date that is one year from the date on which I have signed below.

I may inspect or copy any information used/disclosed under this Authorization.

I understand that the UC OHCA will not, directly or indirectly, receive any items of value from any third party in connection with the use or disclosure of the health information.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the UC OHCA Privacy Program (see the information below), and changing my mind will not affect my treatment. The revocation will not apply to the extent that the UC OHCA has already acted in reliance on this Authorization.

I have read and understand this Authorization, and I have had a chance to ask questions about the use and disclosure of the health information. I authorize the UC OHCA to use or disclose my health information in the manner described above.

_____ _____

*Signature of Patient or Personal Representative** *Date*

_____ _____

Name of Personal Representative (If applicable)* *Relationship to Patient*

**The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

University of Chicago Medicine Privacy Program, MC1000, 5841 S. Maryland Ave., Chicago, IL 60637.
Telephone: (773) 834-9716.